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POPULI

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Family planning needs "new leaders to wipe the slate clean and to bring fresh ideas and new perspectives to our topic," says Malcolm Potts, himself a leader of family planning organizations for many years.

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Herpes Undetected

Many women may be infected with genital herpes without knowing it, according to US researchers quoted by the magazine *New Scientist.* A study of women attending one STD (sexually transmitted disease) clinic found that nearly half the women were infected with the herpes-causing viruses HSV1 and HSV2. Yet, of these women, only one-fifth had symptoms. The researchers say conventional diagnostics—looking for symptoms—therefore fail to detect many cases. They argue that clinics should routinely use newer antibody tests and viral culturing techniques to identify infection.

Fewer Cervical Infections

Using the spermicide nonoxynol-9 with condoms seems to provide increased protection against certain cervical infections than just using condoms, according to a study published in *The Lancet.* The study found a 25-40 per cent fall in the rate of cervical infection with use of the spermicide, depending on the extent of compliance. Researchers say the findings are consistent with earlier randomized studies. But they acknowledge studies in which nonoxynol-9 was found to increase genital irritation and cause ulcers. They warn against relying only on the spermicide to protect against sexually transmitted diseases.

Paraguay: Mixed Desires

Some 44 per cent of Paraguayan women of reproductive age want no more children, according to the recently-released results of the country's latest Demographic and Health Survey. One in four women say they want to postpone pregnancy for more than two years, according to the national survey, which was conducted in 1990. But respondents said the ideal family size was 3.5 children. This, in a country with one of Latin America's highest total fertility rates; the average Paraguayan woman has 4.7 children. In the countryside, the total fertility rate is higher than six children per woman. Knowledge of family planning methods is almost universal, the survey suggests, with 93 per cent of all Paraguayan women knowing of at least one modern method of contraception. Some 35 per cent of women in a sexual relationship actually use a modern method; another 13 per cent use a traditional one, such as periodic abstinence. The family planning needs of one in five women of reproductive age are not being met, according to the survey. Sixty per cent of these women want no more children; another 40 per cent want to space future births.

Condom: Security Threat?

Efforts to promote the condom as an effective means of preventing pregnancy, infection with sexually transmitted diseases, and the spread of AIDS may have hit a new barrier in Sri Lanka. The Associated Press and local newspapers report police arrested a man after finding a condom in his wallet, during a routine search in a suburb of the capital, Colombo. The man, whose name was withheld, reportedly was questioned for more than an hour before being released. His arrest prompted Sriyani Basnayake, medical director of the local family planning association, to write a letter to the police telling them that "condoms are not a security threat." According to the local press, a police official responded: "Why would anyone want to carry a condom in his wallet, unless of course he was up to some mischief?" Sri Lanka's 1987 Demographic and Health Survey found a contraceptive prevalence rate of 61.7 per cent. But only 1.9 per cent of couples used condoms, as compared to a global average of 6 per cent reported in the 1991 State of World Population Report from UNFPA. As of 30 November 1991, there had been a cumulative total of 10 cases of full-blown AIDS in Sri Lanka, despite a growing sex industry, according to the government's most recent report to the World Health Organization.

–V. Nesiah

Mutilation Ban

The Council of the College of Physicians and Surgeons of Ontario, Canada, has prohibited doctors from performing female genital mutilation, sometimes referred to as "female circumcision," according to *WIN News,* published by the non-governmental Women's International Network. The College adds that doctors may find it necessary, during a vaginal delivery by a woman who has been previously submitted to genital mutilation, to surgically disrupt the scar tissue; and that at the end of such a delivery they must not try to reconstruct any infibulation but should instead repair the surgically-incised area. The College is bringing its policy to the attention of the federal government, and is asking that national legislation be developed along these lines. The policy also requires that doctors notify the College of any person performing mutilations. The College says it consulted the World Health Organization, the Inter-African Committee Regional Conference, and the American Medical Association in drawing up its policy. In the College's view, female genital mutilation is not based on religious beliefs, serves only to prevent women from enjoying sex, and can result in serious medical and emotional distress for the women and girls on whom it is performed.

Pharmaceutical Trickery

Almost 92 per cent of the pharmaceutical advertisements that appear in medical journals in the United States are in some way deceitful, according to a recent study by the UCLA (University of California, Los Angeles) School of Medicine. "The implications of our study have enormous consequences for the average person, given previous

research showing that one of the major ways physicians learn about new medications is from journal advertising," says Michael Wilkes, main author of the study, in a recent issue of *Corporate Crime Reporter*. The report found that 40 per cent of the ads surveyed failed to provide the legally mandated minimum of information on efficacy—in fact, few ads provided adequate information on efficacy, safety, and side-effects. Although nearly half of the advertisers claimed their product to be the "drug of choice," 42 per cent of such claims were insupportable, and another 30 per cent were inaccurate; and 20 per cent of the references cited in the ads could not be discovered even after extensive efforts to do so.

UN/J Isaac

Not guilty?

Livestock v. Humans

A dispute is brewing between livestock experts and environmentalists over who is at greater fault in sub-Saharan Africa's land degradation and desertification—humans or livestock.

"The concentration of big herds of livestock has been responsible for the destruction of tropical rain forests and reduction of wildlife resources," says Thomas Mpofu, director of Zimbabwe's Natural Resources Board.

But some 40 livestock experts attending a recent workshop in Zimbabwe on the future of the sub-Saharan African livestock industry argue that people and poverty are the main culprits.

"Most forest destruction in developing nations is caused by poor people who, denied access to land, must clear land to eke out an existence," says Martin Kyomo, a professor and director of the Southern African Centre for Co-operation in Agricultural Research and Training based in Gaborone, Botswana. Prolonged lack of access to land leaves people no choice but to "cut down the last tree," he adds.

John Walsh, director-general of the Addis Ababa-based International Livestock Centre for Africa, says there is no conclusive scientific evidence that widespread desertification has occurred. "Heavy grazing has changed vegetation cover, but has not seriously decreased the productivity of the rangelands," he maintains. "The greatest threat to this region comes from growing human populations and expansion of cultivation."

In 1988, agriculture contributed around 32 per cent of the region's gross domestic product, by official estimates. Livestock products—meat, milk, eggs, wool, hides, and skins—were valued at US$11.8 million.

Meat, milk, and eggs provide around 18 per cent of the protein in African diets, according to the UN Food and Agriculture Organization.

Abortion Conference

The role of the RU486 ® "abortion pill" and other anti-progestins in early medical abortion will be discussed at an international conference in Frankfurt, Germany, 5-6 December. More than 200 health professionals from Europe, the United States, and Australia are expected to attend the conference, entitled "Medical Abortion Services: European perspectives on anti-progestins." The event is being organized by the Europe Bureau of the International Planned Parenthood Federation (IPPF); Pro Familia, the German family planning association; and the United Kingdom-based Birth Control Trust. For more information, contact: IPPF, Regents College, Inner Circle, Regents Park, London NW1 4NS, United Kingdom. Telephone: 071-486-0741. Fax: 071-487-7950.

Offensive Marketing

Batoro tribespeople in Uganda have taken offense at the packaging and marketing of a new brand of condoms, Gemini News Service reports. The condoms are marketed under the brand name Engabu—"shield," in the local language—and are sold in packages bearing the logo of a man in traditional clothing carrying a spear. Says one Batoro: "It [the logo] portrays us as the most sex-hungry people in the whole of Uganda and we don't like that." The Batoro are touchy about being regarded as promiscuous because they reputedly dominated Ugandan prostitution during the 1960s and 1970s. Local AIDS and family planning experts are blaming the marketing problem on the use of a foreign consultant to conduct the four months of market research that preceded Engabu's introduction. The condoms are manufactured in Malaysia.

UNICEF/Carolyn Watson

Can the international community keep up?

World's refugees:

Too many to cope with?

We are in the midst of an unprecedented refugee crisis, with the numbers of dispossessed at some 17 million—more than double their number ten years ago, according to a senior official from the office of the United Nations High Commissioner for Refugees (UNHCR).

"Each day in recent months, 10,000 refugees have been forced to flee their homes, often under appalling physical and psychological conditions," Albert Peters, director of UNHCR's New York office, told the UN Economic and Social Council last month. Many of these refugees end up in "asylum situations which are themselves fraught with insecurity and other dangers."

In the case of Yugoslavia, Peters said, "thousands more are fleeing daily as a result of the ongoing conflict and related human rights abuses, including the terrible process that has come to be known as 'ethnic cleansing.'"

The magnitude of the world's refugee problem is threatening "UNHCR's capacity to respond and the international community's ability to achieve regional and global security," Peters said.

"Urgent challenges confronting UNHCR and the international community include finding ways to ensure that the victims of contemporary events are protected and assisted until such time as they can return home in safety and dignity," he said.

Not all the news is bad, he added, citing UNHCR estimates that, this year, voluntary repatriation—often under UN-mediated terms, as in Cambodia—could see up to three million refugees return home worldwide.

UNHCR reports that Africa is host to about 30 per cent of the world's refugees. Since 1991, deteriorating political circumstances have forced some 300,000 refugees to flee Somalia and southern Ethiopia for Kenya. Somalia's civil war precipitated a massive, spontaneous return of 450,000 refugees to Ethiopia. There are more than a million refugees from Mozambique in Malawi. Strife in Sierra Leone and Liberia has prompted "a major new exodus of refugees" to neighbouring countries, Peters said.

In Asia, over 270,000 refugees from Myanmar, formerly Burma, had poured into Bangladesh by the end of June, causing a full-scale refugee emergency in the world's most densely-populated country. At about the same time, unrest in Bhutan had forced some 65,000 ethnic Nepalese into Nepal.

But, he pointed out, more than 25,000 'boat people' have returned to Viet Nam since 1989. Some 50,000 out of 370,000 Cambodian refugees have returned to their homeland from neighbouring Thailand.

Meanwhile, some 100,000 Afghans crossed the border home from Pakistan, bringing to 600,000 the number to have done so since the year began. According to Peters, before repatriation began in 1990, there were a total of 3.2 million Afghan refugees in Pakistan, and another three million in Iran. Since then, nearly one million refugees have returned home.

Repatriation alone cannot solve the many problems returnees face, however. Efforts must be made to ensure that returning refugees are "properly anchored in the process of national development," Peters said.

New mothers' needs ignored

Many women in developing countries who give birth in hospitals want but do not get family planning services after having a baby, according to an exploratory study by the Association for Voluntary Surgical Contraception (AVSC).

At the Kasturba Hospital in Delhi, India, for example, only 12 per cent of women received any family planning information before being discharged, although 97 per cent said they wanted some.

Researchers visited selected maternity hospitals in Colombia, the Dominican Republic, India, Kenya, Mali, and Turkey. They interviewed about 100 new mothers and 25 family planning service providers in each country, and found that both clients and service providers agreed that family planning information should ideally be given as part of prenatal care, after birth but before discharge, and during postpartum visits to the hospital.

Only 40 per cent of the women interviewed actually received any family planning information before they were discharged, how-

ever. The majority of women interviewed were aged 23-26 years, were married, and already had two or three children. Some said they wanted no more children; others wanted to wait before having another child.

Until now, AVSC claims, little research has been done on women's preferences for and actual experiences with postpartum contraception, although there is plenty of research on what doctors and family planning workers think and do.

"Even though postpartum programmes have been around since the Seventies, little attention has been focussed on the clients' perspective of service delivery," says Evelyn Landry, AVSC's research and evaluation director. "I think the most significant points of the study are that we heard what family planning services women actually wanted during and immediately after their pregnancies, and that providers could become more responsive to women's needs by developing their services along these lines."

Women want information above all else, Landry says. But the specific methods they favour varies between countries. In Colombia, for example, the majority of women plan to use either an intra-uterine device (IUD), sterilization, or the pill. In Kenya, most plan to use the pill or a contraceptive injection. In Turkey, two-thirds say they plan to use an IUD.

Surgical sterilization featured high on the list of women's preferences in Colombia, the Dominican Republic, and India. Since some new mothers may be experiencing postpartum depression when they make this choice, says Landry, "counselling needs to take into account any stresses a woman may have been under during pregnancy and labour." If the pregnancy or delivery was a stressful one, "counsellors should make sure she does not get sterilized immediately but gets time to think. But counsellors should try to facilitate access to these services for women who say they want sterilization while they're still pregnant and have gone through the counselling and informed consent procedures."

"Informed consent" procedures tend to vary, she explains. In AVSC-supported programmes, each woman is made to understand six points before being asked to sign a consent form for the surgery. The six points are: that sterilization is a permanent procedure; that temporary methods are also available; that sterilization is a surgical procedure (the details are discussed); that being a surgical procedure, it has various risks as well as benefits; that there is a chance the surgery might fail, but that, if successful, it is irreversible; and that she has the right to change her mind at any time before the surgery is performed.

The study, *Postpartum Contraception: Perspectives from Clients and Service Providers in Six Countries*, found that by offering services during the postpartum period, programmes can also reduce costs, provide effective contraception to larger numbers of women, and increase the accessibility of services for women. Many health care systems "lose" women after delivery; once women who live in remote areas return to their homes, they may not be seen again by service providers until their next pregnancy.

For more information, contact: AVSC, 79 Madison Avenue, New York, NY 10016, USA. Telephone: (212) 561-8000.

AVSC/B. Gonzales

Overlooked? New mum, Kenya.

Is the developing world better fed?

The number and proportion of chronically undernourished people in developing countries with populations of more than one million have fallen over the past two decades, the Food and Agriculture Organization (FAO) claims.

The number of chronically undernourished people fell from 941 million in 1969-71 to 786 million in 1988-90—or from 36 per cent of the developing world's population, to 20 per cent over the same period.

The findings, released ahead of World Food Day (16 October) and December's International Conference on Nutrition, are based on the minimum energy requirements of a person doing "light, productive work," and take into consideration household consumption over an entire year, according to a press release. The agency acknowledges, however, that the figures "do not reflect those who are undernourished due to temporary or seasonal falls in food consumption or due to problems of household food distribution and infectious diseases."

FAO Director-General Edouard Saouma says the latest figures show that "much progress has been made" in the fight against undernutrition, but that "much still remains to be accomplished."

The inclusion of China's "huge but relatively well-nourished population resulted in the decrease in the proportion of the undernourished worldwide," according to the statement. For the first time, it explains, FAO's estimates include China, the Democratic People's Republic of Korea, Mongolia, and Viet Nam. "The Far East region, with over half the world's

Alexandre Roul/CFF

A thing of the past?

population, strongly influences the global trends in nutrition status," it states.

Although the Far East remains home to the greatest absolute number of undernourished people, the region has also experienced the greatest improvements in reducing undernutrition, according to the study. The numbers fell from 751 million in 1969-71 to 528 million in 1988-90; or from 40 per cent of the region's population, to 19 per cent in the same period. In FAO's view, "the region's progress in food production and distribution, allied with the lowest rate of population growth among all the developing regions, has led to the improvement."

Other regions have not fared as well. The study says that Africa's undernourished increased in number from 67 million in 1969-71 to 168 million in 1988-90. It says the region's food producers, importers, and distributors have not been able to keep up with rapid population growth.

Gains made in Latin America and the Near East during the 1970s were undermined during the 1980s, according to the study. The proportion of undernourished in Latin America remained at 13 per cent throughout this period, but because of population growth, the absolute number rose from 47 million in 1979-81 to 59 million in 1988-90. Similarly, the Near East's proportion remained at 12 per cent over the same period, but the numbers grew from 24 million to 31 million.

For more information, contact: Food and Agriculture Organization of the United Nations, Via delle Terme di Caracalla, 00100 Rome, Italy. Telephone: 39-6-57971 (Rome); (212) 963-6036 (New York).

1994 Conference:

An allegory on the banks of the Nile

It's to be pyramids and obelisks for participants in the 1994 International Conference on Population and Development. The United Nations Economic and Social Council last month approved the Egyptian government's offer to host the Conference in Cairo on 5-13 September 1994.

As host country, Egypt will be responsible for providing premises and facilities for the Conference, funding UN staff travel, and covering Conference support costs.

The Conference will be the fifth international population meeting convened by the United Nations. Technical meetings dealing with demography and population statistics were held in Rome in 1954 and in Belgrade in 1965. Intergovernmental conferences which set goals and made recommendations were held in Bucharest in 1974 and in Mexico City in 1984. The Cairo Conference will be the third such intergovernmental conference.

Announcing his country's selection as host, Dr. Mohamed Noman Galal of the Egyptian Mission to the UN said: "With globalization of world economies and markets, the world's problems have also become ones which transcend borders and hemispheres. This is particularly true of the population issues facing us today."

UNFPA Executive Director and Conference Secretary-General Nafis Sadik expressed gratification at Egypt's "generous offer."

"The 1994 Conference will give the world's governments an opportunity to review the many links between population and development and to establish a specific agenda for effective action in the twenty-first century," Dr. Sadik said.

The Conference's overall theme will be population, sustained economic growth, and sustainable development. Its objectives will be to appraise the progress made in implementing the World Population Plan of Action adopted in 1974 and updated in 1984, and to identify ways to continue to implement it; find ways to further increase awareness of population issues in the international agenda; and recommend actions on key population issues for the next decade.

The population and development recommendations contained in Agenda 21, the non-binding action plan for sustainable development adopted at the Earth Summit in Rio de Janeiro, will also be reviewed at the 1994 Conference, Sadik said.

Last year, the UN Economic and Social Council pinpointed six groups of issues to be examined at the Conference: population growth and demographic structure; population policies and programmes; population, environment, and development; population distribution and migration; population and

women; and family planning, health, and family well-being.

These issues are the subjects of six expert group meetings being convened this year and in 1993 to provide the material and scientific basis for recommendations to be made at the Conference.

In addition, national committees and regional conferences are being called to review their experience with population issues and to propose future action. Their recommendations will be submitted to the Preparatory Committee for the 1994 Conference.

In addition to naming Sadik as Conference Secretary-General, UN Secretary-General Boutros Boutros-Ghali appointed Shunichi Inoue as Conference Deputy Secretary-General. Inoue is the director of the Population Division of the UN Department of Economic and Social Development.

The total cost of preparing for and holding the Conference is estimated by the UN at US$5,651,000, at 1991 rates.

New Guinea-Bissau programme:

Tough issues

A new, US$3.8 million five-year UNFPA programme of assistance to Guinea-Bissau is expected to begin in January 1993. At first glance, it is a country programme like any other: allocating money to projects in maternal and child health and family planning (MCH/FP); information, education, and communication (IEC); and other ubiquitous programme components.

But when the UNFPA Programme Committee met to review the proposed second programme for the West African country, discussion centred on two controversial topics: structural adjustment and a new policy requiring that at least half of the Fund's programme budget be spent directly on family planning.

Committee members discussed the question of how the government can be expected to commit additional money and staff to population and family planning when it is committed to reducing public sector spending and staffing under structural adjustment policies engineered by the World Bank and the International Monetary Fund, according to Wilma Goppel, UNFPA country director for Guinea-Bissau.

Preliminary results of last year's census suggest a national population of 983,367. Some 140 in every thousand infants die before their first birthdays; 914 women died from pregnancy-related causes for every 100,000 live births in 1990. High mortality levels are held responsible for a low rate of natural increase relative to other sub-Saharan African countries—2.3 per cent per year in 1979-91—despite high fertility, at 5.8 births per woman. Yet, a 1991 health ministry study found only 40 per cent of the country's health facilities "effective and functional."

According to a programme document, "all efforts to address the precarious living conditions of the majority of the population, especially children and pregnant women, are constrained by the Structural Adjustment Programme (SAP). Economic reforms, including liberalization, devaluation of the Peso, and a reduction in the active participation of the State in the economy are being implemented."

In consequence, the government cannot hire and pay skilled staff, says Goppel. UNFPA and other donors have had to fund local posts. This is likely to continue on a smaller scale, with the Fund's assistance largely shifting from the capital to the country's more remote regions, as happened with its support of the fledgling Ministry for the Promotion of Women.

The Programme Committee also enforced a resolution, passed by the Fund's Governing Council, requiring that 50 per cent of the programme budget go to family planning. Goppel accepts the logic that family planning should be the main concern, but considers the formula "problematic" in Guinea-Bissau, where "IEC is the key to reducing objections to family planning" in a country where only about 4 per cent of women of childbearing age are thought to be literate.

For example, she says mounting anecdotal evidence suggests female genital mutilation is on the increase, in defiance of the global trend. Experts believe the practice is now spreading among ethnic and urban groups where it is not traditional. In the absence of hard facts and analysis based on surveys—which are planned under the new programme—attempts to explain this trend would be purely speculative. But the problem is thought to be serious enough to warrant a specific IEC strategy to combat it. UNFPA is backing these efforts. Goppel explains that female genital mutilation is a highly prominent topic in the country's social discourse. "It is therefore likely that this will be addressed earlier in campaigns than the issue of family planning. As such, these campaigns will be a valuable testing ground for family planning [IEC] strategies."

She adds that only effective IEC can change the behaviour that has led to high prevalence rates of sexually transmitted diseases and HIV2, the human immunodeficiency virus strain common to Africa.

Political change

Goppel says the future of population and family planning programming in Guinea-Bissau will in large part be shaped by the current transition to multi-party government. Political parties were legalized in late 1991, and elections are expected later this year.

She says political parties are likely to have women's wings or to sponsor women's organizations. In the short term, these groups will aim to win women's votes; depending on how the political system evolves, however, some may grow into organizations with a broader interest in promoting the interests of all women, irrespective of their party affiliation.

Subject to final approval by the Fund's Governing Council, US$2.6 million of the new Guinea-Bissau programme budget has been committed from UNFPA's regular resources; the rest may have to be raised elsewhere, including multi-bilateral sources.

Contraceptive Services:

A Client's Choice

by Elisa Wells and Jacqueline Sherris

Experience shows that client satisfaction is crucial to the success of a family planning programme. Clients are more likely to be satisfied when they can choose from a broad variety—or "mix"—of contraceptive methods, and when they are assured of high quality care.

Programmes that offer a broad method mix are likely to attract more acceptors than programmes that offer limited method choices because the contraceptive needs of more women will be met. One reason for this is that when a variety of methods is available, clients who are dissatisfied with one method can switch to another, more acceptable one rather than rejecting contraceptives altogether.

UNFPA/Lily Solomon

Clients should speak up, service providers should listen.

High quality care—including complete, accurate and culturally-appropriate information, safe and effective services and follow-up care rendered by fully trained personnel, and a reliable supply of contraceptives—is equally important to a programme's success, and to the health and satisfaction of family planning clients.

These are among the findings and recommendations of a forthcoming report from the World Health Organization (WHO), *Contraceptive Method Mix: Guidelines for Policy and Service Delivery*, prepared in collaboration with the Program for Appropriate Technology in Health, a non-governmental organization based in Seattle, United States of America.

When helping clients choose a contraceptive method, family planning service providers should be aware that many people seeking their services have already decided upon a method. Unless a client requests a method that is medically unfit for them or unavailable, providers should honour the client's choice. A 1991 study of contraceptive continuation in Indonesia found that 91 per cent of women who were given the method they requested continued using it one year later, as compared to 28 per cent of women who had been denied their original choice.

Clients who have not decided on a specific method often need information and advice about available methods. To ensure that clients select the method best suited to them, providers should ask about their reproductive intentions, risk of infection with sexually transmitted diseases (STDs), whether or not they breastfeed or intend to do so, and their willingness to use a contraceptive every time they have sexual intercourse. Providers should also find out what access clients have to contraceptive supplies and to medical facilities for follow-up, as well as possible medical factors that might prevent them from using some methods.

Once clients choose a method, providers should inform them about how to use it correctly; possible side effects, complications, and interactions with medications; expected return to fertility after discontinuing the method; and what to do if the method fails or complications occur. Discussing potential side effects and how to manage these is especially important.

How clients choose

A client's choice of contraceptive method is influenced by factors that vary from couple to couple and as clients move through their reproductive years. These factors include:

- personal concerns, such as the user's age, parity, reproductive intentions, frequency of intercourse, relationship with partner, influence of others in contraceptive decisions, and familiarity and level of comfort with her body. Couples who have frequent intercourse may

Elisa Wells, M.P.H. and Jacqueline Sherris, Ph.D. are, respectively, Associate Program Officer and Senior Program Officer at the Program for Appropriate Technology in Health (PATH). *They wish to thank Dr. Leila Mehra of WHO for her guidance and suggestions. For more information on the WHO contraceptive guidelines series, contact: Maternal and Child Health, World Health Organization, 1211 Geneva 27, Switzerland.*

choose a longer acting method because they find methods used at each coitus to be inconvenient. A woman who is uncomfortable touching her genitals may not want to use a barrier method or periodic abstinence techniques that require evaluation of cervical mucus.

- health considerations, including the client's general health, reproductive history (including history of contraceptive use and of infection with STDs), and contraindications to—or medical incompatibility with—various methods. Certain conditions—including anaemia, infections or STDs, cervical and uterine abnormalities, and circulatory disorders—can render some contraceptives unsuitable.
- the cost and accessibility of methods. Modern methods may not be affordable, or even readily available, in some remote areas. Some methods require one large payment beyond the means of many clients, rather than a series of smaller, more manageable payments. Lengthy clinic visits or extended travel to obtain contraceptives mean lost income and time away from young children. There may even be a psychological price to pay in being made to feel embarrassed or demeaned by a provider.
- religious and cultural beliefs, and misinformation about various methods. Because Muslim women are prohibited from praying and Hindu women from cooking during menses, methods that cause extended menstrual bleeding may be unacceptable. Many clients make contraceptive decisions based on incorrect information obtained from friends and relatives or confusing educational campaigns. Unsubstantiated rumours about the adverse effects of the pill and intra-uterine devices, or IUDs, are common throughout the world.

Real world limitations

But programmes are shaped by more than clients' needs and preferences. Issues of policy, supply, delivery system requirements, STD prevalence, cost-effectiveness, and availability of medical follow-up are also tied to the contraceptive mix provided.

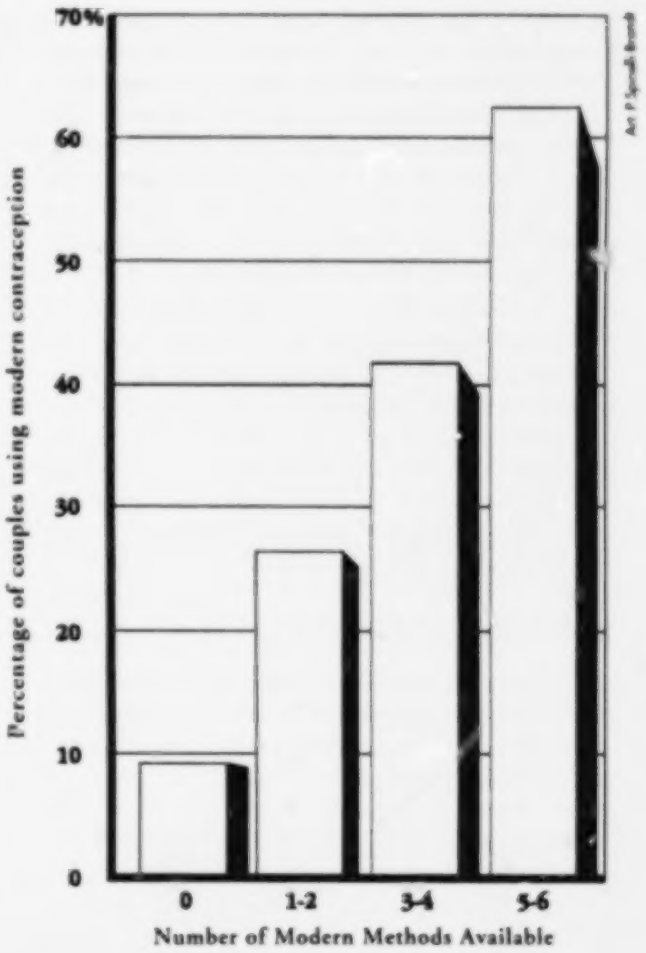
Some family planning-related policies can restrict the range of methods available to users—for example, by limiting use, manufacture, or importation of a method; restricting the type of service delivery system that can be used; unnecessarily requiring blood tests or pelvic exams before providing a method; limiting use of certain methods based on age, parity, marital status, or spousal consent; or offering certain incentives (see box, next page).

Programmes must be able to ensure a consistent supply of a given contraceptive—whether it is produced locally or obtained from donors or international corporations—before including it in the method mix. Programmes must also ensure the methods they provide can be properly administered initially, and that there is adequate follow-up. Providers must be trained and back-up medical facilities must be available. For methods requiring removal, such as IUDs and implants, trained personnel must be readily available to clients who wish to stop or switch methods.

How to deliver the goods? Over the years, family planning services have evolved from primarily clinic-based delivery systems to a broad range of clinic- and community-based, social marketing, and commercial systems. The characteristics of each method determine what forms of delivery are most appropriate. For example, a social marketing or community-based system may be well suited to resupply methods such as condoms, spermicides, or the pill; a clinic-based system is more appropriate for implant insertions and sterilization.

Programme planners need to assess the prevalence of STDs and infection with HIV, the human immunodeficiency virus, in their area. Condoms, education and coun-

Contraceptive use increases as more methods are made available, data from 36 developing countries shows:



Note: A method is considered "available" if over half of couples have ready access to it.

Source: Ross J.A. et al. Management Strategies for Family Planning Programs. *New York: Center for Population and Family Health, Columbia University, 1989.*

DO INCENTIVES LIMIT CHOICE?

Programmes that offer incentives have been widely criticized for interfering with clients' freedom of choice. For example, providers who are paid for each intrauterine device inserted may be more likely to pressure their clients to accept IUDs than other methods. Community incentive schemes, which provide benefits to the community when individuals accept family planning, can lead to peer pressure in the absence of adequate information and counselling for individuals.

In contrast, incentive schemes that make methods more accessible may effectively increase the choices available to clients. For instance, voluntary sterilization, which can require time away from work or family duties, may only be an option for clients if they receive compensation for lost time and travel expenses. As with any programme policy, careful regulation and monitoring are needed to ensure that incentive policies benefit clients and do not result in coercive practices.

–E.W. & J.S.

selling about STDs and HIV, and diagnosis and treatment services are a must where STD/HIV prevalence is high.

Programme managers need to consider the comparative costs of providing various methods. Those that require frequent resupply by a trained provider, such as injectable contraceptives, will have higher delivery costs than longer-acting methods that require less frequent supply, although these may be more expensive initially. Decisions cannot be made on the grounds of cost alone, however. A programme that provides only long-acting contraceptives cannot satisfy the contraceptive needs of all its clients; consequently, a significant proportion of women will choose not to use any method.

Although ideally programmes should offer a broad mix of methods, this may not always be feasible or appropriate. Policy makers, programme managers, and administrators must design and run programmes that respond to individuals' needs and work within real world limitations, which include shortages of funding and trained personnel and insufficient infrastructure for safe service delivery. This new report tells them that by providing clients with a variety of appropriate contraceptive options and quality services, programmes can help clients achieve their desired level of fertility, improve contraceptive prevalence, and accelerate fertility decline.

Stage Fright

by Abid Aslam

Seventh-grade students at Calabar High School for boys, on the outskirts of Kingston, Jamaica, are in for a shock when they turn up for their first Drama class. Expecting to horse around and play make-believe, they are confronted with some of the realities of their lives—including their nascent sexuality.

At Calabar, Drama is a required course for seventh-, eighth-, and ninth-graders, boys aged 10-15 years. Another 100 of the school's 1,700 boys participated in extra-curricular drama club activities last academic year, according to Pauline Matthie, one of the school's two Drama teachers.

Faced with a shortage of published plays for schools, and especially of scripts for all-boy casts, the students and Drama teachers at Calabar have taken to writing and performing what they know: the difficulties of poverty, unemployment, and violence; the joys and anxieties of adolescence and family life; and the mysteries and responsibilities of sexuality.

The initiative has paid off for Calabar, where Drama has been taught for more than 15 years. The school won nine gold medals and six national awards from the Jamaica Festival Commission, for its 1991 national schools' festival production of "Ghetto Child," a play written by Cecele Dixon, who also teaches Drama, and directed by Matthie.

There is more at stake than awards. Some 57.8 per cent of males report having their first sexual experience before they were 14 years old, according to the findings of the 1987 Young Adult Reproductive Health Survey conducted by the National Family Planning Board, a government-funded independent statutory body. The average age at first intercourse for males is 14.3 years. One in four births is to a teenage mother, according to official figures.

"Ghetto Child" is about a boy named Junior, whose father abandons the family in its crowded tenement home when Junior's mother gives birth to an unplanned sixth child. Junior wants out of the ghetto, and resorts to stealing. He gets a gun. Miguel, the eldest child and family idol, finds Junior with the gun and tries to wrestle it away from him. The gun goes off in the struggle, killing Miguel.

Junior's father returns to console the family, and sees his sixth child for the first time—sees in the little boy the hope of replacing Miguel, the son for whom he had dreamt great dreams before the couple's energy and meagre income were sapped in nursing and rearing four other children. The children must be raised as best they can. They must understand this tragedy had as much to do with unplanned

Abid Aslam edits POPULI.

UNFPA/A. Aslom

Rehearsing Trapped.

pregnancies and desperation as with the fatal fight and gunshot.

Devastated by his deed, Junior runs out through the audience. The curtain is lowered. We do not know what becomes of him.

"Our plays often come out of discussions with the boys themselves," says Matthie, who joined the school in 1986. "Many topics in the boys' lives emerge during drama sessions. We discuss them in terms of cause and effect, problems and their solutions. Then we incorporate them into our plays" and other dramatic forms, including monologues, speech choirs, and dance.

Such topics include anger, alienation, and vengeance, which form the basis of "Trapped," a play about the spiritual struggles of a young man sent to prison for being in the wrong place at the wrong time.

Sex was the subject of a number of skits produced and performed by Calabar students during family planning week last October. In one skit, the boys made recommendations on how best to conduct sex education. The significance of their effort is underscored by the National Family Planning Board's survey report, which states: "A greater proportion of females used contraception at first intercourse if they had sex education in school and discussion of contraceptive methods was part of the course. For males, having sex education seemed to make little difference in whether they used contraception or not." The report adds that four in 10 girls and one in 10 boys used contraception the first time they had sexual intercourse.

In their skit, the Calabar boys made these recommendations:

First, teachers should not think of their students as perverts for asking questions about sex and sexuality; the boys are simply not educated at home.

Second, teachers should be thick-skinned about awkward questions. As one student put it: "If I ask the teacher, 'What's a period, Miss?', she shouldn't take it personally. It's just a question."

Third, teachers should speak their students' language. Matthie explains: "Normally, boys don't discuss sex in biological terms. They are not accustomed to words like penis and vagina, which make them uncomfortable and can be disruptive in class. The words they are used to are more acceptable, words like cock, wood, or long John, or even teapot. Many parents use this word at home when the boys are small."

Sex education is not on the class timetable at Calabar, but is offered by the school's female guidance counsellor. Many other schools provide some form of family life or sex education in this way. There is no mandatory national curriculum, so not all of these schools provide information on contraception and safe sex. There has been talk in official circles about making family life education compulsory, however.

Many teachers are uncomfortable about the prospect of having to answer questions about sexuality in class, Matthie says, adding that sex education can make it tough for them to maintain control.

Matthie smiles for a moment. "Students test you as teachers," she says. "If you can't hold your ground, especially on issues like these, you get nothing worthwhile from them."

UNFPA/A. Aslom

The Calabar speech choir in rehearsals.

READEX
FICHE

Enough confusion about women's needs

by Farida Sher

Women must be allowed to make their own decisions regarding their fertility and their lives. No one, under any pretext or banner—be it politics, religion, or feminism—has the right to coerce them to accept or reject family planning.

Women, more than anyone else, know only too well the joys and trials of childbearing, motherhood, and family life. As the nurturers of children and society, they are fully aware of the consequences of their choices. Others must not be allowed to assume these choices on their behalf.

Thankfully, this is the essence of the women's treaty forged by NGOs (non-governmental organizations) at the Global Forum held alongside the Earth Summit in Rio de Janeiro. The treaty is the very creditable result of 200 hours of discussion among participants whose views were polarized. In the end, there was no disagreement that women must make their own decisions about reproduction.

No one here confuses her head with her womb.

But this is not the end of a story; it is the beginning of what will either be a story of advancement for women and their societies, or one of continued confusion and opportunities laid to waste at the hands of those who would use selective science, religion, and ideology to serve interests other than women's.

Some will maintain that overconsumption and profligate lifestyles in the industrialized countries and among developing-country elites deserve a monopoly on our attention. To my mind, there is no conflict between the need to drastically modify consumption patterns, to share resources equitably, and to plan populations.

Some will continue to argue that family planning is not an environmental cure. Yet, there is no conflict between the facts that poverty is a major environmental problem and that family planning is an important means of poverty alleviation.

Perhaps these points are repetitious, but the persistence and often highly emotional resistance to these ideas from some at Rio suggests that they have not yet been laid to rest.

It is strange to hear women from both industrialized and developing countries oppose family planning with claims that it is coercive or that it offends religious sensitivities. In Pakistan, a predominantly Muslim and illiterate society, my experience has been that religious reasons for not accepting family planning are almost always given when there is confusion or fear about contraceptives, inadequate information, and a lack of quality services. Where these concerns are allayed, even highly religious women and men have been practising modern contraception. But contraceptive services are few and of generally poor quality. The number of self-induced and backstreet abortions performed in a country where a woman cannot have a legal abortion even if she has been raped, indicates that people are desperate enough to ignore religion and the law. Are these women not coerced by the absence of meaningful choices and quality services.

There is certainly a need for more and better information and services. And programmes overwhelmed by the desire to control population growth at the expense of all other family planning considerations have resulted in unpardonable crimes against women. But the claims of some, such as the militant priest-writer interviewed in the Rio newspapers, that "women who visit a clinic because they have a headache leave the place without any awareness that they have been sterilized," betray a contempt for women's intelligence. Perhaps Pakistani women are smarter, but no one here confuses her head with her womb.

Women must beware the unforgivable arrogance of those from industrialized countries who presume to speak on behalf of the developing world when their own societies enjoy a relative abundance of education, healthcare, and family planning services; and those from developing countries who claim to represent silently suffering majorities from whom they would withhold the means to make informed and free choices. Ironically, these spokeswomen are able to participate in international fora in large part because they have had access to contraception.

We have had enough confusion about what women want and need. We want and need sufficient food, education, and healthcare; access to reliable information, safe contraception, and quality family planning services; and long-overdue material recognition for our special roles, productive and reproductive, in the social, economic, and physical environment. We need to meet the demands of other NGO treaties made in Rio, for social transformation and economic justice, since international data and experience confirm that birth rates decline when there are improvements in women's social, economic, and health status and in general standards of living.

Above all else, we need to defend ourselves against those who would bar us from our own rights, responsibilities, and bodies.

Farida Sher, a sociologist and freelance consultant, has been an active feminist for more than 20 years. She is on the Family Planning Association of Pakistan's technical committee on women, youth and environment and national council, and is a member of SIMORGH, a Pakistani women's resource and publication collective.

Where have all the leaders gone?

by Malcolm Potts

Family planning has always had strong leaders, individuals of conviction, courage, and charisma, willing to fight—sometimes against great odds—to uphold reproductive freedom and to bring family planning choices to the underprivileged. Pioneers such as Margaret Sanger, the nurse who founded Planned Parenthood in the USA and who went on to help launch the International Planned Parenthood Federation (IPPF); Lady Rama Rau of India; Fernando Tamayo of Colombia; Elise Ottesen-Jensen of Sweden; Jae Mo Yang of Korea; Marie Stopes, the British biologist who sought sexual fulfillment for women in marriage and fought for birth control clinics; Clarence Gamble, the international philanthropist; William Draper, who by sheer persistence and force of personality secured funding for IPPF and UNFPA; and Rei Ravenholt, who was one of the first in the international donor community to see that family planning involves listening to what people want, not telling them what to do.

These and others made up an illustrious, memorable, and exceedingly effective group. A few of them are still working and visible. But one of the paradoxes of our controversial and rapidly changing field is that pioneers can also fossilize surprisingly rapidly. We need new leaders.

Our movement's pioneers had to be strong personalities capable of breaking through the barriers raised to family planning by politicians, clergy, and medical and legal professions. They won many battles, but huge challenges are still before us. We are emerging from a difficult and frustrating ten years. Although the demand for family planning increased explosively in many developing countries during the 1980s—as is well demonstrated by the spectacular successes in family planning in several parts of the world—family planning has in other countries been pushed into the background by idiosyncratic political changes. Reproductive choice is under renewed attack from antediluvian religious and political leaders who voice extreme and minority opinions—for example, that teenagers are not sexually active—with increased shrillness. This, when Demographic and Health Surveys from around the world and the tragedy of unsafe abortion tell of a compelling need for greatly expanded family planning services.

What should we be looking for in the next generation of leaders?

Pioneers, by definition, had to be recruited from outside family planning. Today, family planning has a career structure of its own. Is it throwing up the right people? Do we need leaders who are less temperamental than some of those who went before (nobody, for instance, could work with Marie Stopes), but who may be better administrators? Probably. Certainly, the challenge of doubling services in a relatively short time to try to meet couples' unmet needs is going to require exquisite administrative skills.

Yet family planning leaders must never lose the drive that Elise Ottesen-Jensen called being "brave and angry." After all, family planning is about a basic human right that, like other crucial human freedoms, must be staunchly and assiduously defended.

We need younger family planning professionals to carry on and expand our work. But we also need them because the most important mistakes are often the very ones the present generation of decision-makers find most difficult to see. Sometimes our job descriptions are overly long on qualifications and experience and too short on flexibility and dedication. After all, Margaret Sanger had a rather thin CV when she began her crusade.

Our job descriptions are overly long on qualifications and experience and too short on flexibility and dedication.

We need new leaders to wipe the slate clean and to bring fresh ideas and new perspectives to bear on our topic. The best way of helping ourselves and encouraging new leadership is to give younger people responsibility.

If those now in leadership positions in family planning are to succeed, and if they are to have access to the most precious of all resources—human skills—then they must be confident that there is a supremely important job to be done. Like William Draper, they must be committed to the rapid growth needed in our profession to get the job done. They must groom successors. We can be certain the talent is there.

Family planning is important for the very reason that it looks a generation ahead. We must plan ahead in our family of family planners. Make way for a new generation of leaders! You are out there, and I suspect *you* already know who you are.

Dr. Malcolm Potts is president of International Family Health, London, a new institution working in international family planning and AIDS prevention. Throughout the 1980s, he was president of Family Health International, a non-profit research organization based in the United States, and led it in a period of expansion and entry into AIDS prevention activities.

Planned Parenthood/World Population

Margaret Sanger, 1879-1966.

Sanger Biography

When Margaret Sanger insisted on exercising her right, granted by the First Amendment to the United States Constitution, to openly discuss sexuality and contraception, she "changed the social discourse of her time and of our own." This, according to biographer Ellen Chesler in *Woman of Valor: Margaret Sanger and the Birth Control Movement in America.* Born Margaret Higgins, her first marriage, in 1902, was to William Sanger, an architect. She had studied nursing, and combined her knowledge of health care with socialist ideals, joining Socialist Party Local 5 in New York City in 1911. She opened the first birth control clinic in the US five years later, having seen women die after self-induced abortions without open and legal medical assistance. Within weeks, the police closed the clinic and jailed Sanger. She went on to lecture in the US, Britain, India, and Japan, and in 1921 organized the first American Birth-Control Conference in New York City. Winston Churchill was among the sponsors of the Conference. Sanger died in 1966, at the age of 87. Chesler writes: "Since her death the rebirth of a vigorous feminist movement has given new resonance to her original claim that women have a fundamental right to control their own bodies." Published by Simon & Schuster, New York, and priced at US$27.50.

China's Dilemmas

A new report from the United States-based Population Reference Bureau finds that China's move toward a market economy has created some new jobs but has eliminated even more. Unemployment continues to be serious in the cities, and more than 140 million jobs were lost in rural areas when agricultural communes were disbanded. Thousands of peasants migrate illegally to the cities each year, and join a "floating population" of domestic workers, street hawkers, or unemployed poor. The capital city, Beijing, faces serious shortages of drinking water in the near future, as air and water pollution in urban areas worsen and harmful agricultural techniques deplete forests and grasslands. More than one million new teachers are needed to keep up with the continuous waves of new students; at the same time, about 90 million Chinese will be older than 65 years by 2000. Only a fraction are currently eligible for basic retirement benefits. The report, *China's Demographic Dilemmas*, is available at a cost of US$8.00 from: Population Reference Bureau, 1875 Connecticut Ave., N.W., Suite 520, Washington, D.C. 20009, USA. Telephone: (202)483-1100.

Conference Newsletter

Population 94 is the official newsletter of the 1994 International Conference on Population and Development. The newsletter updates readers on preparations for the decennial conference, which is scheduled to be held in Cairo, Egypt, on 5-13 September 1994. Published quarterly. For more information, contact: Population 94, ICPD Secretariat, c/o UNFPA, 220 East 42 Street, New York, NY 10017, USA. Telephone: (212) 297-5222/5230/5244. Fax: (212) 297-4915. Telex: 7607883.

Africa Surveys

Africa Demographic and Health Surveys, a chartbook, summarizes the findings of the 11 Demographic and Health Surveys conducted in sub-Saharan Africa between 1986 and 1990. The region has the world's fastest rates of population growth and, despite improvements, the highest infant mortality rates and lowest life expectancy. The countries surveyed are: Botswana, Burundi, Ghana, Kenya, Liberia, Mali, Nigeria, Senegal, Togo, Uganda, and Zimbabwe. For more information, contact: Population Reference Bureau, International Programs, 1875 Connecticut Avenue, N.W., Suite 520, Washington, D.C. 20009-5728, USA.

Abortion Care

A report from International Projects Assistance Services (IPAS) looks at the contraceptive needs of women who have had abortions. *Meeting Women's Needs for Post-abortion Family Planning: Framing the Questions* sets out to address the issues surrounding the provision of abortion and family planning services from a medical, legal, personal, and international perspective. Chapters focus on issues such as contraceptive methods, quality of care, health system design, and legal and policy implications. Available at a cost of US$9.50 from: IPAS, P.O.Box 100, Carrboro, NC 27510, USA.

HIV and Development

HIV and Development is a 16-page introduction to what is known about HIV, the human immunodeficiency virus. It sets out to explore HIV's impact on economic and social development as well as the difficulties developing countries face in managing the pandemic. Available at a cost of US$2.95 plus US$1.00 (shipping) from: The Panos Institute, 1717

Massachusetts Avenue, N.W., Suite 301, Washington, D.C. 20036, USA.

Woman's Journal-Advocate

Almost one in four women in the United States will be physically abused by a current or former partner at some point in their lives, according to an American Medical Association (AMA) study reported in the June 1992 issue of *The Woman's Journal-Advocate*. The AMA says this domestic violence "cuts across all racial, ethnic, religious, educational, and socio-economic lines," and urges doctors to routinely screen their female patients for it. *The Woman's Journal-Advocate* is published 12 times a year and is available from: P.O. Box 81226, Lincoln, NE 68501, USA. Suggested subscription price: US$1.00 per US$2,000 annual income.

Research Grants

The DHS Small Grants Program is offering funding for analysis projects involving the use of data from the Demographic and Health Surveys, specifically in the fields of mortality, morbidity, and population dynamics. Projects must last no longer than one year. Some preference will be given to applications from developing countries. For more information, contact: Macro International, 8850 Stanford Boulevard, Columbia, MD 21045, USA. Telephone: (410) 290-2800. Fax: (410) 290-2999.

World Bank

Population and the World Bank: Implications from Eight Case Studies is an attempt by the World Bank to provide a broad view of the demographic, social, and economic changes that have occurred in developing countries since it started lending money to population projects in 1968. The report focusses on population programmes in Bangladesh, Brazil, Colombia, India, Indonesia, Kenya, Mexico, and Senegal. Published by the Bank's Operations Evaluation Department. Priced at US$10.95. Available from: World Bank, Office of the Publisher, 1818 H Street, N.W., Washington, D.C. 20433, USA. Telephone: (202) 473-2033.

Cairo Workshop

The Johns Hopkins University School of Hygiene and Public Health plans to hold its first Arabic workshop on "Advances in Family Health Communication," in Cairo, Egypt, 28 November-17 December. The workshop will focus on the process of designing, implementing, monitoring, and evaluating IEC (information, education, and communication) programmes and activities. For more information, contact: Johns Hopkins University School of Hygiene and Public Health, 527 St. Paul Place, Baltimore, MD 21202, USA. Telephone: (410) 659-6300. Fax: (410) 659-6266.

Woman Power

The Power to Change: women in the third world redefine their environment, presents narratives of positive change brought about by women, in the face of the often negative impact of conventional development programmes in their lives and on their environment. The book is an anthology of columns written by correspondents for the Women's Feature Service (WFS), a New Delhi-based international news-feature service. It proceeds "from the understanding that development impacts women and men differently and that the 'development decades' have seen an alarming trend towards the feminization of poverty," according to WFS Director Anita Anand. For more information, contact the publisher, Kali for Women, A-36 Gulmohar Park, New Delhi 110 049, India. Or: Women's Feature Service, 49 Golf Links, New Delhi 110 003, India. Phone: 91-11-462-9886. Fax: 91-11-462-6699.

Better Evaluation

Improving Family Planning Evaluation: A Step-by-Step Guide for Managers and Evaluators, by José García-Núñez, is the latest title in the Kumarian Press Library of Management for Development series. The author is director of evaluation for Pathfinder International. Available from: Kumarian Press, Inc., 630 Oakwood Avenue, Suite 119, West Hartford, CT 06110-1529, USA.

Women's Work

The Revaluation of Women's Work, by Sheila Lewenhak, is a study of the dimensions and status of female labour in industrial and developing countries. In this updated and revised edition, the author sets out to show how changes in both types of country are altering the male/female division of labour in trade, management, and, above all, technology. Available from: Earthscan Publications Limited, 3 Endsleigh Street, London WC1H 0DD. Telephone: 071-388-2117. Fax: 071-388-2826.

Training Course

The Indonesian National Family Planning Co-ordinating Board, BKKBN, is organizing a two-week course, "Women in Family Planning and Development: The Indonesian Experience." Scheduled for 7-20 October, the course will be held in the capital, Jakarta and various field sites. For more information, contact: Program Co-ordinator, International Training Program, BKKBN, P.O.Box 1186, Jakarta 13650, Indonesia. Telephone: 809-8018/800-9029/800-9045, Ext. 254,256. Fax: 809-7387/819-4532.

Child Labour

Some 100 million children are being exploited as labourers worldwide, according to the latest information from the International Labour Organisation (ILO). Child labour is more than just a matter of children helping with household chores. It often involves starting full-time work at too early an age, missing out on schooling, and working under hazardous conditions. Child labour is believed to endanger a child's psychological and social development, whether the child is put to work in a factory or in a brothel. And it is a problem shared by industrial and developing countries alike.

Lost Youth

The ILO Minimum Age Convention of 1973 sets a minimum age of 12-13 years for light work, depending on when children complete primary school. As of 31 October 1991, only 38 countries had ratified the convention.

Employment Prospects

One in three Indian carpet workers is a child. Where do most child labourers work? On family and commercial farms; in factories and mines; as domestic servants, particularly for girls; on the streets, washing windshields or selling chewing gum or newspapers; and in red light districts, as child prostitutes.

Earnings

Child prostitutes are usually among the highest paid child workers, earning an average US$15.00 per night in the Philippines and US$45.00 in the United States in the early 1980s. Child street vendors sometimes earn more than their adult counterparts. Child wage-labourers' earnings are usually negligible, especially when compared to adult pay. As domestic servants, children are often paid in kind, not in cash.

Running Risks

Child workers have to take enormous chances to get the benefits of their labour, such as they are. Labour inspectors in Peru discovered 71 secret cemeteries containing the bodies of children who worked in the gold industry. Half of the 50,000 bonded child workers in Pakistan's carpet industry die before their twelfth birthday. Child prostitutes are often infected with HIV, the human immunodeficiency virus, and sexually transmitted diseases, and are frequently harrassed, assaulted, or killed by police. Child street vendors are often crushed by vehicles on busy streets. Child workers are generally malnourished and vulnerable to infectious diseases.

UNICEF

Early career opportunity?

Agenda for Action

Poverty is often the root cause of child labour. Experts say it is therefore necessary to combat poverty in order to reduce child labour. But child labour must also be rendered unattractive and unprofitable for employers. How? By: improving and enforcing legislation; promoting school enrollment, for example by ensuring that primary school is free and universally available; raising public awareness; supporting community action; and removing children from hazardous environments such as factories, mines, and construction sites.

Sources:

- International Labour Organisation: *1992 World Labour Report; Combating Child Labour*, 1988.
- Alec Fyfe, *Child Labour*, Polity Press, 1989.

This month's Dictionary and Notebook were researched by Vaseeharan Nesiah.

DICTIONARY

Cafeteria Approach

The term "cafeteria approach" is used to describe family planning programmes which offer prospective and actual clients a choice of contraceptive methods at one place. The idea is to make it convenient for clients to choose, or change, contraceptive methods to suit their own needs and desires.

The cafeteria approach is more expensive to operate than family planning services which provide a limited selection of methods, at least initially. Studies show that the cafeteria approach is more cost effective per averted birth in the long run, however.

The term is attributed to S.S. Agarwala, who used it in a paper at the 1966 Industrial Conference on Family Planning, held in Calcutta, India.

(**Sources**: Indian Chamber of Commerce, *New Approach to Family Planning*, 1966; G.B. Simmons et al, "Cost-effectiveness analysis of family planning programmes in rural Bangladesh: Evidence from Matlab", *Studies in Family Planning* 22(2), 1991; Population Council.)

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